Practice pointer - Consultations for people from minority groups

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PRACTICE POINTER

Consultations for people from minority groups

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This article provides practical suggestions on ways to improve communication with people from minority ethnic and faith groups

Most developed societies are ethnically, linguistically, and religiously diverse, and recent trends in migration mean that this diversity is set to increase. Irrespective of background, most people want (and most health professionals aim to provide) high quality care that is accessible and sensitively delivered. For many people in minority groups, the care sought and the professional knowledge base, skills, and competencies needed to deliver such care are no different from those needed for people from the majority population, but in some instances standard approaches may need to be modified to achieve comparable outcomes. Making the effort to do so is important for ethical and legal reasons, but also because it will be appreciated and remembered. Conversely, failures in communication often have a lasting negative effect on the doctor-patient relationship; in particular, such failures can erode trust, not only in the clinician, but also in the health service in general.

Challenges to delivering culturally competent and sensitive care

The NHS was created to serve the needs of a more homogeneous society than we have at present. Data on variations in quality of care, persistent health inequalities, and lower satisfaction with healthcare provision show that the NHS has difficulty in adapting to meet the needs of minority populations, particularly if these needs differ from those of mainstream society.[1] This challenge is greatest when delivering care to older people who have recently migrated from parts of the world with very different societal structures; those who are not entitled to stay permanently; and those with limited English.

Most healthcare professionals will also have had little training in understanding the complex association between culture, health, and healthcare delivery, thereby increasing the risk of cultural misunderstandings and diminishing the potential for creatively exploring the development of individually tailored care plans, often out of fear of making a cultural faux pas.[2]

Summary of the evidence for interventions

Ethnic minorities remain marginalised from many research projects, and the few studies that do include them usually fail to present ethnic specific subgroup analyses.[3] Furthermore, much of the more focused work on these populations has been descriptive or qualitative, mostly aimed at understanding disease burden and illness experiences. Thus, rigorous experimental studies to guide management decisions are lacking. Most of our suggestions are therefore based on low level evidence—expert opinion or uncontrolled studies. At present, we have no indication that more robust evidence to guide practice will be forthcoming in the near future.

Strategies and approaches to enhancing delivery of care

Practice profiling

Few practices have reliable data on patients' ethnic origin, religion, or other important information—such as main language spoken—which makes it difficult to obtain a reliable overview of the populations being served. The recently introduced quality and outcomes framework point for recording the ethnic origin of newly registered patients is a small, but none the less welcome, incentive that should help initiate a culture of collecting and, in due course, using such data to help determine needs and to audit care.[4] In the meantime, however, you can acquire an overview of the practice population using National Statistics' online *Neighbourhood statistics*, which include data on ethnic origin, religion, and more than 50 other datasets of potential interest. We recommend using the recently introduced postcode defined "super output areas" because these can easily be mapped on to the practice area.[5]

Improving access to care

Despite experiencing worse outcomes for a range of conditions, some ethnic minority groups have lower attendance at health services. Similar problems have also been described for uptake of some preventive health services, such as cervical smear testing and bowel cancer screening. These problems can be mostly overcome, but they often require innovative

approaches that include working with local communities to formulate solutions. For example, a multifaceted, community based intervention in Walsall, which included working with religious centres and local community leaders to increase awareness of the importance of attendance, resulted in a dramatic and sustained reduction in non-attendance to paediatric services.[6] Although these improvements probably result from the intervention, this cannot be concluded with certainty because this study had no control groups.

Creating a welcoming atmosphere

It is important to create a welcoming atmosphere, and this can be achieved by paying attention to simple matters such as using clear signs and translating the most important information into the main languages spoken by the practice population. An example of a useful sign to display in a range of relevant languages is one explaining that all efforts will be made to enable patients to see a doctor of the sex of their choice. Similarly, a well labelled box for comments and suggestions can also be useful. Some practices now have reading materials available in key languages in the waiting room. None of these endeavours needs to be onerous or expensive because, in our experience, if approached, members of the local community will help their practice with basic translating and pass magazines and books that they no longer need on to their surgery.

Providing a water jug in the surgery toilet and recognising major religious festivals (with something as simple as a poster in the waiting room, as is now commonplace in schools) are other inexpensive initiatives that convey an appreciation of minority cultures.

Staff training

Although diversity training is now available for many hospital based staff, access to such training is more limited in primary care. Such training is important, however, not least because of the implications of the Race Relations (Amendment) Act,[7] and it should leave staff with a clear understanding that—although often well intentioned—a "we treat everyone the same" approach is the foundation of institutional discrimination, which was defined by Sir William Macpherson as, "The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."[8]

Staff also need to be made aware of the dangers of (often heated) public debates about multiculturalism affecting quality of care—everyone needs to understand that, irrespective of personal beliefs, the essential principle of serving in the patient's best interests must never be compromised. Practice based significant event audits might provide a vehicle for such diversity training.[4] Details of some of the better known training courses can be found on the NHS Specialist Library for Ethnicity and Health.[9]

Responding to diversity in the consultation

Communication

Genuine attempts to put people at ease transcend linguistic and cultural divides and will (eventually) be understood. "Is there anything important that I need to know about you, your beliefs, or your customs?" is a helpful open question that is likely to be well received by all, irrespective of background.

Responding to the language needs of people with poor English

People with limited English are dependent on an interpreter to convey anything more than the simplest of messages, and—given that making a diagnosis depends very much on taking the patient's history—this need must not be overlooked. A professional interpreter is preferable, but this may not be possible, particularly for unscheduled appointments, home visits, and out of hours care. Many clinicians therefore continue to use family translators; other advantages of using a family member include the greater opportunity for continuity and shared understanding. None the less, it is still better to use a professional interpreter to prevent misunderstanding information given, breaching confidentiality, and deliberate censoring of information. These problems are compounded if the translator is a child, and this practice can seldom, if ever, be condoned. When access to a professional interpreter is not possible, we suggest using a professional telephone based interpreting service such as Language Line,[10] which provides immediate real time professional support. On a practical note, it requires access to a speakerphone. Details of language needs should also be given when referring patients to hospital or other agencies, so that appropriate provision can be made.

ADDITIONAL EDUCATIONAL RESOURCES

Bhopal RS. *Ethnicity, race and health in multicultural societies*. Oxford: Oxford University Press, 2007.

Gatrad AR, Brown E, Sheikh A. *Palliative care for South Asians: Muslims, Hindus and Sikhs*. London: Quay, 2006.

Helman CG. *Culture, health and illness*. London: Hodder Arnold, 2007.

Henley A, Schott J. *Culture, religion and patient care in a multi-ethnic society*. London: Age Concern England, 1999.

Kai J, ed. *Ethnicity, health and primary care*. Oxford: Oxford University Press, 2003.

Kai J, ed. *Valuing diversity*. 2nd ed. London: Royal College of General Practitioners, 2006.

Kleinman A. *Patients and healers in the context of culture*. Berkeley: University of California Press, 1980.

Sheikh A, Gatrad AR. *Caring for Muslim patients*. 2nd ed. Oxford: Radcliffe Press, 2007.

Spitzer J. *Caring for Jewish patients*. Oxford: Radcliffe Press, 2003.

Szczepura A, Johnson M, Gumber A, Jones K, Clay D, Shaw A. *An overview of the research evidence on ethnicity and communication in healthcare*. London: Department of Health, 2005. www2.warwick.ac.uk/fac/med/research/csri/ethnicityhealth/research/communicationsreview.pdf.

Summary of recommendations

- Carry out a practice profile to understand the demographic profile of the patients served
- Investigate whether problems with access to care exist and if so how they can be minimised
- Create an inclusive welcoming atmosphere
- Ensure that staff have diversity training
- Be aware of cultural "blind spots"
- Provide interpreting services
- Provide translated written materials
- Try to understand and respect different social norms

Some people who cannot read English may also have difficulty in reading their mother tongue, in which case translated written materials are not helpful; multilingual audiovisual materials are now beginning to be developed for such people. Simply assuming that written translated materials will be unhelpful is however inappropriate because some people will be literate in their mother tongue; others will often have access to someone who can read to them.

One of the main practical challenges facing busy clinicians is how to access translated materials. This has been difficult in the past, but access is now improving through the NHS Specialist Library for Ethnicity and Health, which is making high quality materials available online. It also lists dates of key religious festivals and provides practical support and advice by responding to questions posed by professionals.[9]

Understanding and respecting social norms: gender considerations

Most people from minority groups will not care whether their clinician is a man or a woman, except in certain contexts—such as when discussing sexual problems, or when the patient perceives an intimate examination is needed. But even in such cases, if this request is difficult to facilitate, most will, if given an adequate explanation, accept this.

Societal norms about dealings with the opposite sex may affect the consultation in other ways. It is, for example, unusual for South Asians to shake hands with members of the opposite sex. Therefore, we do not initiate a handshake with someone of the opposite sex from these groups but will respond if a hand is extended. Misunderstandings can also be caused by lack of eye contact, which is considered by some to be modest behaviour and should therefore not be taken as an insult.

Conclusions

Effectively responding to diversity is challenging, typically requiring additional resources, time, and skills from practices and professionals who are often already stretched on account of serving deprived communities. When thinking how best to cater for minority groups, practices should take into account both organisational considerations and the individual doctor-patient encounter. Sensitively responding to the challenge of diversity can be deeply rewarding, because we are not only responding to those who are often most marginalised and in need of our help, but helping to develop services that are more responsive to the needs of our patients in general.

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9 NHS National Library for Health. *Ethnicity and Health Specialist Library*. www.library.nhs.uk/ethnicity/.
10 Language Line Services. www.languageline.co.uk/.